

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**=62-026553**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 99 Primary Registration District No. \_\_\_\_\_ Registrar's No. 43

**FILED AUG 14 1962**

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>TAYLOR</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Amity</u>		Length of stay in 1b <u>1 DAY</u>	c. CITY OR TOWN <u>NEAR VILLISCA</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>8 MI. S.E. OF TOWN</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>ELLIS</u>	Middle <u>CLARK</u>	Last <u>McCOY</u>	4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1962</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1927</u>	9. AGE (last birthday) <u>34</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>HEPBURN, IOWA</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
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13a. FATHER'S NAME <u>JOHN H. McCOY</u>	13b. MOTHER'S MAIDEN NAME <u>VERLA V. DOW</u>	14. NAME OF HUSBAND OR WIFE <u>EDNA IRENE PREEO</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	17. INFORMANT <u>EDNA IRENE McCOY, VILLISCA, IOWA</u>
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18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Interval between onset and death <u>10 min</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Sudden Death - Coroner Notified</u>	COUNTY _____ STATE _____
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21. I attended the deceased from _____ and last saw him/her on _____ Death occurred at <u>9:20 P.M.</u> on the date stated above, and to the best of my knowledge, from the cause stated.
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22a. SIGNATURE <u>Harold Fowler</u> (Degree or title)	22b. ADDRESS <u>Mayville, Mo</u>	22c. DATE SIGNED <u>7/3/62</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7-31-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CLARINDA CEMETERY</u>	23d. LOCATION (City, town, or county) <u>CLARINDA, IOWA</u>
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24. FUNERAL DIRECTOR <u>Pelcher Funeral Home, Mayville, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>8-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Hertie E. Davidson</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

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Rev. 4/59

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AUG 28 1962

AUG 17 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*W. E. Summerfield*

Licensed Embalmer No. 3007

P. O. Address Stewartsville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.